TennCare Operational Protocol

Chapter 3:
Benefits and Cost-Sharing

Section 3.1
Benefits

3.1.1 TennCare Benefits

The benefits available to TennCare enrollees are listed in the TennCare Rules and Regulations, for both TennCare Medicaid and TennCare Standard, available on the Bureau's website. Definitions of specific services and services that are excluded from coverage are also listed in the rules.

Reference: See Rules 1200-13-13-.04 and 1200-13-14-.04 (Covered Services) and Rules 1200-13-13-.10 and 1200-13-14-.10 (Exclusions).

These rules should be consulted for information on particular limitations and coverage details.

TennCare benefits include, but are not limited to, the following:

- Community health services
- Dental services (for children under age 21)
- Durable medical equipment
- Emergency air and ground transportation services
- EPSDT services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21
- Home health care
- Hospice care
- Inpatient and outpatient substance abuse treatment services
- Inpatient hospital services
- Lab & X-ray services
- Medical supplies
- Mental health case management
- Mental health crisis services
- Non-emergency transportation services
- Occupational therapy
- Organ and tissue transplant services and donor organ/tissue procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services
- Physical therapy services
- Physician services
- Private duty nursing services
- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery

- Renal dialysis clinic services
- Speech therapy services
- Vision services (for children under age 21)

Additional benefits are available for children under 21 as medically necessary.

The concept of medical necessity is an important factor in the coverage of services under TennCare. TennCare Rule 1200-13-16 outlines the criteria that must be met for a service to be considered "medically necessary."

In addition to the above-listed services, there are other services that Managed Care Contractors may choose to offer as "cost effective alternatives." These services are provided at the sole discretion of the MCCs when they believe that they can meet an enrollee's needs at a lower cost than a service that is covered. Policy Statement BEN 08-001, located on the TennCare website, describes cost-effective alternatives in more detail.

Additional information about coverage arrangements is contained in TennCare Policies found on the Bureau's website. See the following Policy Statements:

BEN 06-001 – Erectile Medication(s)
BEN 06-002 – Coverage of Adult Dental Services in a Hospital Emergency Department
BEN 07-001 – Hospice
BEN 08-001 – Cost Effective Alternatives
CON 07-003 – MCCs' Responsibilities to Provide Services to TennCare Children Receiving Special Education Services
PAY 07-001 – Hospice and Patient Liability
QC 05-001 – Orthodontia Providers
http://www.state.tn.us/tenncare/pol-policies.html,

3.1.2 Benefits for Dual Eligibles

Dual eligibles are Medicare beneficiaries who are also eligible for some form of assistance from TennCare. A list of the categories of dual eligibles, and a description of each category, is presented in Section 2.1.3.

The TennCare benefits to which dual eligibles are entitled are summarized in Table 3-1 below. Payments of Medicare premiums are made by the Bureau of TennCare through a "buy-in" agreement with CMS. Payment of deductibles and coinsurance is also made by the Bureau of TennCare. An MCC may choose to pay Medicare premiums and/or cost sharing for beneficiaries who are not entitled to these payments from TennCare.

Table 3 - 1
TennCare Benefits for Dual Eligibles

Categories of Dual Eligibility	Eligible for TennCare Services Not Covered by Medicare?	What TennCare Covers
QMB	No	Medicare Part A and Part B premiums. Deductibles and coinsurance for all Medicare services, regardless of whether or not these are covered by TennCare.
QMB Plus	Yes	Medicare Part A and Part B premiums. Deductibles and coinsurance for all Medicare services, regardless of whether or not these are covered by TennCare. All TennCare services not covered by Medicare.
SLMB	No	Medicare Part B premiums.
SLMB Plus	Yes	Medicare Part B premiums. All TennCare services not covered by Medicare.
QI	No	Medicare Part B premiums.
QDWI	No	Medicare Part A premiums.
Other Medicaid/Medicare Duals	Yes	Medicare Part B premiums, except Medically Needy. Deductibles and coinsurance for all Medicare services that are also covered by TennCare. No payments for Medicare deductibles or coinsurance when the Medicare service is not covered by TennCare, unless the enrollee is under 21 or an SSI beneficiary. All TennCare services not covered by Medicare.

Section 3.2
TennCare Cost-Sharing

Premiums. There are no premiums charged in the TennCare program.

Deductibles. There are no deductibles charged in the TennCare program.

Copays. Certain enrollees have copay obligations on certain services. Most of these copays are calculated based on the enrollee's income information, which is collected by the Department of Human Services when the enrollee applies for TennCare. Enrollees must report any changes in income to their DHS caseworkers at the time such change occurs. Enrollees must provide a completed employer statement showing the new income. Self-employed enrollees must provide appropriate proof of income changes, such as the most recent quarterly tax statement filed with the IRS. Information about documentation to be supplied and the reporting of changes to enrollee information is provided in *Tennessee Code Annotated (T.C.A.)* 71-5-110.

Copays are collected by the provider at the time of service.

Additional information about enrollee cost sharing can be found in TennCare's Rules.

Reference: See Rules 1200-13-13-.05 and 1200-13-14-.05.

3.2.1 Pharmacy Copays

The pharmacy copay applies to the following populations:

- All TennCare adults, aged 21 and older, <u>except</u> for the following:
  - Adults who are being served in Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, or Home and Community-Based Services waivers
  - Adults who are getting prescriptions for family planning drugs or supplies
  - Adults who are receiving emergency services
  - Adults who are pregnant
  - Adults who are receiving hospice services
- All TennCare Standard adults who are enrolled in the SSD program[1]
- All TennCare Standard children with incomes at or above 100% of poverty

The pharmacy copay is $3.00 for brand-name drugs. There is no pharmacy copay required for generic drugs.

[1] TennCare Standard adults in the Discontinued Demonstration Group (see Section 2.1.2) do not have a pharmacy benefit.

3.2.2 Non-Pharmacy Copays

Non-pharmacy copays apply to the following populations:

- All TennCare Standard enrollees with incomes at or above 100% of poverty, except for those in the SSD program

Table 3-2 shows the copays that are in effect until December 31, 2008. Table 3-3 shows the copays that will go into effect on January 1, 2009. The new copays are consistent with those charged in the *CoverKids* program.

Table 3 - 2
Current TennCare Copay Schedule (Until December 31, 2008)

	Income Level of 100% to 199% of Poverty	Income Level of 200% of Poverty and above
Hospital emergency room service (waived if admitted)	$25	$50
Primary care provider services other than preventive care	$5	$10
Community Mental Health Agency services other than preventive care	$5	$10
Physician specialists (including psychiatrists)	$15	$25
Inpatient hospital admissions	$100	$200

Table 3 - 3
TennCare Copay Schedule to Take Effect on January 1, 2009

	Income Level of 100% to 199% of Poverty	Income Level of 200% of Poverty and above
Hospital emergency room service (waived if admitted)	$10	$50
Primary care provider services other than preventive care	$5	$15
Community Mental Health Agency services other than preventive care	$5	$15
Physician specialists (including psychiatrists)	$5	$20
Inpatient hospital admissions (waived if readmitted within 48 hours for the same episode)	$5	$100

3.2.3 Aggregate Annual Cost-Sharing Cap (to be Effective January 1, 2009)

In order to be consistent with the *CoverKids* program, TennCare will begin recognizing an aggregate annual cost-sharing cap for each child who is subject to copays.

For each child who is subject to copays, the state will calculate 5% of the family's total income for the length of the child's eligibility period. This amount will be considered the "aggregate annual cost-sharing cap." When this cap has been reached, the enrollee will have no additional copays for the remainder of his year of enrollment. Families will be responsible for keeping receipts for copays made and will notify the Bureau of TennCare when they believe the aggregate annual cost-sharing cap has been reached for their child. When this happens, the Bureau of TennCare will notify the MCCs that the child is to be exempted from copays for the remainder of his eligibility period. The MCCs will be responsible for making the necessary systems modifications as well as notifying their providers to make certain that copays will no longer be collected. This policy will be implemented on January 1, 2009.

3.2.4 TennCare and Third Party Insurance

Some TennCare Medicaid enrollees have other health insurance along with their TennCare coverage. This occurs most often when an enrollee has a job with insurance, but their overall circumstances still qualifies them for TennCare Medicaid. Sometimes an enrollee may have purchased a policy on his own. Attachment B is a listing of what is and what is not considered to be health insurance under TennCare. TennCare is always the payor of last resort, except in a few circumstances where federal law states otherwise.

When an enrollee has third party liability (TPL), that third party must be billed before submitting the bill to the enrollee's TennCare MCO. Providers must follow the third party's requirements for obtaining payment (i.e., getting prior authorization) in addition to the requirements for submitting claims to the MCO. Information about how to handle TPL can be found in Policy Statement CON 05-001 "MCCs' and Providers' Responsibility When Enrollees has Third Party Copays and/or Deductibles." This policy can be found on the Bureau's website: http://www.state.tn.us/tenncare/pol-policies.html

3.2.5 Seeking Payment from a TennCare Enrollee

As a general rule of thumb, applicable copayments as described in the previous sections are the only payments that providers can accept from TennCare enrollees. One of the conditions of participation in TennCare for providers is that they accept the payment amounts that they receive from the MCCs as payment in full.

There are only two circumstances when providers can seek payment, other than copays, from a TennCare enrollee. One is when the service requested is not covered by TennCare and the provider informed the enrollee, prior to providing the service, that it is not covered. The other is when the service requested, such as a sixth prescription within a month's time, exceeds an established benefit limit.

The procedures to be followed in either of these circumstances are outlined in TennCare Rule 1200-13-13-.08(5) & (6) and 1200-13-14-.08(5) & (6).

Reference: See Rules 1200-13-13-.08(5) & (6) [TennCare Medicaid] and 1200-13-14-.08(5) & (6) [TennCare Standard].

Policy Statement PRO 08-001 – Seeking Payment from a TennCare Enrollee